Likewise, Samuel Preston has pointed out that, when compared with other age groups such as the elderly, relatively little information on the status of children is available to us.[13] Nevertheless, by compiling existing information, he is able to demonstrate a striking new inequity based on age; the dwindling public expenditures on behalf of children are associated with disastrous effects in education and social welfare. Even mortality data—when assessed by the demographer's model life tables (which indicate how much change typically occurs in age-specific death rates per unit change in life expectancy at birth)—show children at substantial disadvantage when compared to other age groups, especially the elderly.

In the face of this deteriorating situation, the clouding of the camera's eye, which has exposed the status of child health in the past and initiated a chain of various social reforms, almost seems like a conscious effort to shut out anything which might interfere with the sunny outlook of a master showman. Yet we cannot really escape from the parlous times in which we live. We engage in aggression abroad, while we stockpile death and squander our natural resources at home, and we ignore the inequities that exist in populations both at home and abroad. Even the human appeal of maternal and child health is distorted by those whose reverence for life is restricted to life in the womb.

As Dr. Starfield points out, however, there have been giant steps and baby steps in the past. If the balance of forces in human nature favors altruism over self-indulgence, if good is a greater force than evil, the pendulum will swing—not merely back to where it was when it started the retrogression, but forward by another giant step. We can prepare for the future not by looking to the past, but taking note of how far we have come and how far we still have to go to achieve the aspirations of maternal and child health.

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Without Guns, Do People Kill People?

Firearms killed 33,000 Americans in 1982, accounting for one injury death out of five: 1,756 of these deaths were classed as unintentional, 16,575 as suicide, 13,841 as homicide, 276 as legal intervention, and 540 of undetermined intent [National Center for Health Statistics (NCHS) unpublished data].

Firearms are the second leading cause of death in the United States for ages 15–34, with motor vehicles in first place and cancer a distant third.[1,2] For ages 30 to 54, firearms generate as many deaths as motor vehicle crashes.[1] Despite the severity of the problem, data on non-fatal firearm injuries are virtually non-existent.[3]

As with deaths from other causes, the risk of death from firearms is not equally shared by the population. The death rate from unintentional injury is almost 10 times as high in low-income areas as in high-income areas; rates are especially high among White teenagers, Blacks age 15–34, and Native Americans.[1]

Firearm homicide, accounting for two-thirds of all homicides, has a rate among Blacks that is more than six times the White rate.[1] One Black out of 40 will be murdered with a gun between ages 20 and 44. In urban areas, the statistics are even worse; firearm homicide rates for Blacks in large cities are more than 10 times the overall rate for the US population (unpublished data).

Firearms cause 57 per cent of all suicides. These differ from other suicides in that the rates are highest in low-income areas. Firearm suicide rates are highest in elderly males, especially White males; a lower peak is seen among males in their 20s.[1]

For any population group, the availability and lethality of firearms are major determinants of such death rates. This is vividly illustrated by data from the Aarhus region of Denmark published in this issue of the Journal.[4] There, the rate for all assaultive injuries treated at hospitals is almost as high as the rate in Northeastern Ohio: six vs eight per 1,000 population[4,5] [Comparable data are not available for other US areas]. The Danish homicide rate, on the other hand, is only one-fifth the rate for Ohio, 1.4 vs 7.2/100,000.[1,6] The discrepancy is largely explained by two facts. First, firearm injuries have an extremely high case fatality rate (15 times the rate for knife assaults in the Danish study). Second, private ownership of guns is permitted only for hunting in Denmark but is common in the US, where half of all households have guns and one in five has a handgun.[7] South Carolina data suggest that gun homicide rates are highest in localities where gun ownership rates are highest.[8]

We often hear that "Guns don't kill people, people kill people." Especially relevant to this statement is the observation by Hedeboe and his colleagues[4] that injuries were inflicted by whatever was most available—most commonly fists or feet, followed by other objects likely to be close at hand. Sometimes, no doubt, a person who is intent upon killing someone seeks out a lethal weapon. Far more often,

gun-inflicted deaths ensue from impromptu arguments and fights: in the US, two-thirds of the 7,900 deaths in 1981 involving arguments and brawls were caused by guns [unpublished data, Federal Bureau of Investigation]. These deaths would largely be replaced by non-fatal injuries if a gun were not handy.[9] Thus, a far more appropriate generality would be that "People without guns *injure* people; guns *kill* them."

Despite the overwhelming importance of gun availability, the problem of firearm injury and its solution are far from simple. Much attention has been given to the possibility of restricting the sale and ownership of handguns and handgun ammunition, because of their very low benefit-risk ratio. Although the size and concealability of handguns is of no benefit except for killing people, proposals to limit private ownership or use of small, easily concealed handguns evoke strong reactions from the firearm industry, the National Rifle Association, and many gun owners.[10] Lawsuits against manufacturers, based on their having introduced unreasonably hazardous products into the stream of commerce, may eventually help to stem the tide of handgun production and sales.[9] Other approaches to reducing firearm injuries include development of less lethal handgun ammunition and design of firearms so they cannot be discharged easily by young children, or inadvertently by teenagers and adults. Given the magnitude of this public health problem, the time is past due to attack it on many fronts.

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Whither Goeth the Model Standards?

Before the end of this year, *Model Standards: A Guide for Community Preventive Health Services* will be released in Second Edition. A review of the developmental process which has brought the model standards movement to this point is in order.

In early 1976, the Director of the Center for Disease Control (CDC), Dr. David J. Sencer, noted that while this country had standards for almost everything—including the number of stitches in a baseball's cover—there were no generally accepted standards for community preventive health services. In October of that year, under Dr. Sencer's guidance, CDC began discussions with the Association of State and Territorial Health Officials, the United States Conference of City Health Officers (now Local Health Officers), the National Association of County Health Officials, and the American Public Health Association (APHA) which led to the establishment of a collaborative work group to develop model standards for community-oriented preventive health services. That work group consisted of representatives from each of the four named associations and from CDC.

In August 1977, the President signed Public Law 95-83, the Health Services Extension Act of that year. Among its provisions was a statutory requirement that standards for community preventive health services be developed. The sponsor of that particular initiative was Senator Robert Stafford of Vermont who had been pursuaded by his State Health Officer, Dr. Anthony Robbins, of the critical need for such standards. The conference report accompanying PL 95-83 made note of the work already underway by the collaborative work group, and called on the Secretary of Health, Education, and Welfare to rely heavily on the expertise of that group. Thus, what began as a collaborative, voluntary effort had become a Congressionally mandated responsibility.

As the work group pursued its charge, a series of experiences demonstrated the complexity of its mission. It became increasingly clear that the idea of local public health standards was neither entirely new—nor totally welcome—to the public health community. A thorough literature review, presentations by States which had already adopted public health program standards (most notably North Carolina and Maryland), and the publication of a Georgetown University Health Policy Center study[1] reinforced the fact that many others were already struggling with the standards concept.

As early as the 1920s, APHA committees were doing extensive work to standardize public health procedures for the first time. Their Public Health Appraisal Forms stimulated self-inspection among health departments—city, rural, and local—and over the next three decades, the APHA Committee on Administrative Practice coordinated efforts to improve the services provided by local health units. The APHA Executive Board encouraged development of a project similar to this collaborative effort in the early to mid-1970s. It was obvious to the work group that the variety of approaches with which others had experimented was at least equal to the number of participants in the process. As Dr. Hugh Tilson was to observe, "Somehow, what should be an 'undisputed good'—clear, realistic, feasible, understandable, and useful standards by which our profession will be known and by which the people for whom we care will be able to hold us accountable—has been a source of controversy over the years."[2]